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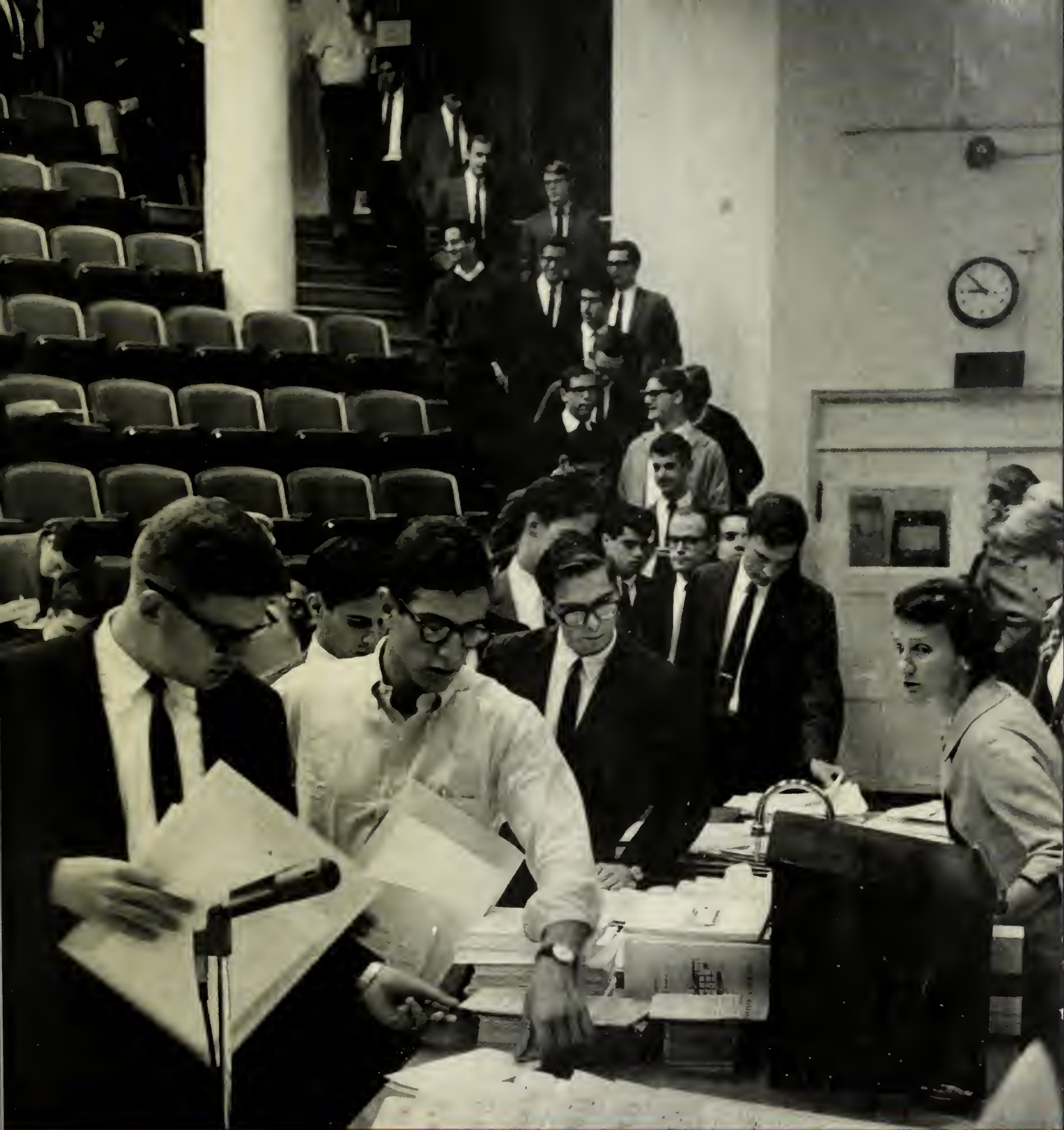


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Harvard Medical
Alumni Bulletin

41
1966-67



HARVARD MEDICAL Alumni Bulletin

Fall, 1966

LETTERS

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To the Editor:

The articles by Drs. Culver and Taylor in the 1966 Summer issue of the HMAB were delightful, well-reasoned and outward-looking bright spots in an otherwise dismal panoramic view of what ails contemporary medical education and educators. As proof, Dr. Gardella could have stopped after his first paragraph and Dr. Hiatt never got anywhere near his last.

In the gang navel scrutiny imaginatively entitled, "A Round Table Discussion on the Heart Disease, Cancer and Stroke Program," Prof. Pollack successfully avoided mentioning the fundamental fact that the alleged reasons for the necessity of the Program—i.e., the ignorance of the majority of the practicing physicians in the United States and the unavailability to the average American of the means for accurate diagnosis and effective treatment—simply do not exist. He and the other participants hastily swore fealty to false gods, mumbled briefly about parochial problems, and then hurried on to a thinly disguised plotting together as to how to turn this program into just another stone in the Mightiest of all Medical Monoliths.

Although Dr. Knowles' graceless diatribe certainly demonstrated to every reader, if not to himself, why his three visits to the sixteen hospitals on the fringes of civilization failed to lure them into his professional dead-fall, he at least expressed an elemental awareness of two outsiders, the patient and his physician, for which, I suppose, we should knuckle our forelocks and lick a boot or two.

But the thing that bugs those of us who chose to leave the Medical Meccas for the frontiers of medicine most of all is the increasingly exclusive and unhealthy, almost incestuous relationship between the medical schools and the affiliated hospitals. This monomaniacal preoccupation was never more clearly depicted than in said issue. Let me assure you that the greatest divisive influence on the relationship between the medical schools and the practitioners—and even the practice—of medicine is the academic egocentricity so uniformly displayed in one article after another,

one opinion after the next.

There seems to be no consciousness at all at the academic level that the solutions to many of the intellectual, professional and economic problems posed already have been found and are in operation at the community or sub-academic, if you must, level. Group practice, inservice programs, medical student recruitment, nursing school expansion, the stimulus of the annual infusion into the practicing profession of service-minded, board-qualified neophytes, shirtsleeve and coffee conferences and clinics with uncondescending visiting firemen, the increasing attendance at the decreasing number of pertinent post-graduate courses offered almost off-handedly by the medical schools—all of these are widely operative and important.

However, the greatest single antidote to the Alice in Wonderland-type planning of the AAMC and its subservient AMA Committee, and perhaps the last bastion of defense for the physician primarily concerned with the welfare of patients as people, is the non-affiliated intern-resident program. This type of environment bears the same relationship to the large medical school hospital service that the good small college does to the huge impersonal state university. The doubts and fears expressed by Dr. Kaufman '66 (Summer, HMAB, page 34), are quickly and kindly allayed in such a setting. Daily close association with well-trained, interested and articulate visiting men is undeniably preferable to the anonymity of an over-populated intern-fellow-resident hierarchy. The balance between staff supervision and personal responsibility is more neatly struck in the well-staffed non-affiliated hospital.

One peek is still worth two finesses; seeing first-hand and wrestling personally with the variety of diagnostic puzzles and therapeutic dilemmas now common in all approved hospital educational programs is still better than glimpsing them over six rows of heads or holding to the point of paralysis the third retractor on the left. Principles and theory are fine but the man who will make the diagnosis first is the man who has seen it before and the woman who writes orders for

insulin most frequently will learn how to use it soonest. As Dr. Kaufman put it, "The wisdom of medicine derives from the doctor's contact with the patient under his care, and all of medicine's many worlds revolve around the illness of the individual." He is much more likely to receive this wisdom in the community setting than on the research-teaching carrousel from which he and so many of his peers are loathe to dismount.

BARKLEY BEIDLEMAN '44
Pensacola, Florida

Passes All Bounds!

To the Editor:

What has gotten into your editorial board, approving the current cover as it has? Some recent numbers have been pretty bad, but this one passes all bounds. While the rest of your alumni body are busy improving a cockeyed world—via providing therapy, your board is taking the easy path, and helping in the general degeneration. The contents of the Bulletin are all right; it is the covers that are at fault. A simple lettering of the Bulletin's name, a photograph of some favorite faculty members or a drawing at \$10 by any commercial artist would cover requirements. If you need the \$10, I'll send it.

I am almost ashamed to be a class agent in an alumni body that perpetrates such a job. I took my copy to lunch yesterday at a fellow classmate's of my college, and passed it around the table. The picture was universally condemned—no art, no humor, nothing informative, no nothing.

If you intend to keep on with these childish pranks, please don't send me any more copies of the Bulletin—I should hate to have it delivered at my office. The Cornell or Columbia doctor next to me saw that cover and laughingly asked whether our board really are Harvard Medical graduates.

JOSEPH K. SURLS '17
New York

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No. 1

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COVER: Bright and early on September 16, a larger than usual class of one hundred and thirty-five students registered for HMS I. By noon-time not only had they been welcomed but they had also attended their first lecture (pages 20-22).

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The opinions of contributors to the Bulletin do not necessarily reflect those of the Editorial Staff.

Furthering Our Plans



by Dean Robert H. Ebert

WITH THE BEGINNING OF A new academic year and the completion of my first year as Dean of the Harvard Medical School, it seems an appropriate time to share with you a few thoughts about the state of Harvard Medicine today and its future.

Much has changed in medical education in recent years, and ever more sweeping changes will take place in the years ahead. Because no institution can realize its aims and grow to its full potential without the understanding and approval of those who care most deeply for its well-being, I should like to increase the dialogue between the School and its Alumni—especially those who have demonstrated thoughtful concern.

Although you are undoubtedly familiar with the new strength that has come to the School as a result of the Program for Harvard Medicine, let me reiterate a few of the salient facts: in 1949 there were 58 tenure positions in the Faculty of Medicine; today there are 113. Endowed, named professorships have more than doubled during this period, for a total of 53 as of this date. Ten years ago, in 1955, 317 Teaching and Research Fellows studied at the Harvard Medical School; in the academic year 1965-66 there were 781. The Francis A. Countway Library of Medicine has been built, thus fulfilling a cherished dream and inaugurating a new era of library service for the medical community.

The new resources available through the Program have averted a serious financial crisis. During the Program the Alumni also met their responsibilities for annual giving to the Harvard Medical Alumni Fund which helps support scholarships and sustain current operations. We are counting on the continued growth of the Alumni Fund as a major source of on-going support. The funds that you and others have contributed assure Harvard's independence and its continued leadership in medical education.

HAVING ACHIEVED SO MUCH, what now lies ahead for Harvard Medicine? An entirely new set of problems for medical education has arisen as a result of the combination of many factors; the rapid acquisition of new scientific knowledge, the increased complexity of medical practice, the growing shortage of medical manpower, an insistent public demand for better health care at reasonable costs. Upon a handful of leading medical schools has developed the responsibility for devising the means to meet these requirements while preserving the essentially voluntary nature of the organization and distribution of medical care. The Federal Government can do much in the way of providing resources, but Congress must necessarily respond to various public pressures. Unless the major medical schools and teaching hospitals undertake the necessary medical, economic and social research and develop effective plans to provide better medical care to all segments of society, the vacuum may be filled by legislative acts and administrative decisions, many of which will be politically motivated.

Over the last decade there has been a constant increase in Federal funds available for research. Congress has provided millions of dollars to medical schools since World War II, chiefly in short-term project grants, to accelerate progress in solving the riddles of disease. Much has been accomplished with these funds and much will continue to be. But there are hazards inherent in excessive reliance on short-term grants and in the growing involvement of university medicine with the Federal Government.

One danger lies in the inherent nature of short-term grants, whether they are made by private foundations or by the Government. They cause an academic illness called "projectitis," or an unhappy addiction to limited objectives. Pressures are created to probe primarily where reward seems immediate or dramatic, or where grants are available, while fields of great potential value to national health may be neglected.

A decision by the Federal Government to provide long-range institutional grants for medical schools would not completely resolve our problems. We would still have to have adequate resources under our own control, so that we might continue our association with the Government confident in our ability to act independently. The Surgeon General has said:

"Does Federal support inevitably imply Federal control?" In responding to his own question, the Surgeon General replied, "My answer, with no apology, is a qualified yes."

Both President Pusey and I are gravely concerned about the consequences attending the rising percentage of Federal funds in financing the Harvard Medical School. The Government now provides over 60 per cent of the School's annual budget. Most other medical schools are even more dependent upon Federal funds. One must remember that the tremendous influx of Federal medical research grants has been in response to insistent public demands for better health. Universities, in their response to these demands, have tried to serve the public good by undertaking extensive Government-sponsored research programs. However, the risk is great that in this process a university may gradually lose effective control over its own decision-making.

At Commencement in 1962, President Pusey warned against overdependence on Federal support when he said: "We at Harvard do not want the Federal government to take over financial responsibility for us. Far from it! Rather, we are working as hard as we can to maintain our financial independence as the basic requirement for maintaining any independence at all." Continuing, "We fear that at some future time our new associate may begin to make demands upon us inconsistent with the true character of an independent university. When that time comes—perhaps we should anticipate, when those repeated times come—we wish to be able, and we firmly intend to say no."

Addressing himself specifically to the problems of Federal support of medical education, Mr. Pusey has said: "... in an institution like the Harvard Medical School it is necessary to have a strong network of full-time appointees who are not beholden for their support to the Federal government or to anyone other than the university itself; who must be free to direct their own activities as a faculty. . . ." Hence our effort to gain private capital for more tenure professors.

My own position as Dean—and one which I have made clear to many Government officials, foundation heads, corporation officers and individual philanthropists—is that educational institutions must maintain a healthy balance of Federal and private monies. There is

John P. Merrill, internationally known as a pioneer in kidney transplantations, is Director of the Cardio-Renal Division of the Peter Bent Brigham Hospital. A native of Hartford, Conn., he received his undergraduate education at Dartmouth. After graduating from the Harvard Medical School he trained at the Brigham, and joined the Faculty of Medicine in 1948. With his colleagues in both the Departments of Medicine and Surgery at the Brigham Hospital, he has helped to make it a world center for artificial kidney and transplantation research. For his achievements, Dr. Merrill has won many honors and awards, among them, the Alvarenga Prize of the Philadelphia College of Physicians, the Amory Prize of the American Academy of Arts and Sciences, and *Modern Medicine's* Distinguished Achievement Award.

Dr. Merrill also participated in the Program for Harvard Medicine. As an officer of the Aesculapian Club, of which he was President in 1964-65, he helped to raise \$163,000 to endow and equip the Aesculapian Room in the Countway Library.



George C. Walker brings unusual expertise and insight to the task of co-directing the Committee. Long active in Harvard affairs, Mr. Walker is a member of the Committee on University Resources and the Committee to Visit the Medical School and School of Dental Medicine. He served both the Program for Harvard College and the Program for Harvard Medicine, the former as a member of the President's Committee and chairman of the effort to complete the campaign during its final year. As a member of the Executive Committee of the Program for Harvard Medicine from 1961 to 1965, Mr. Walker further demonstrated his keen devotion to the University and a remarkable talent for attracting financial support for it from business and philanthropy.

Mr. Walker has been associated with Electric Bond and Share Company in New York since his graduation from Harvard College, and became President in 1944. He is Vice President and Trustee of the Roosevelt Hospital and a member of the Council on Foreign Relations.



much that the Government can do in the way of providing resources, but Congress must respond to various public pressures. This fact of political life underscores my own belief that unless the leading medical schools and teaching hospitals do the necessary medical, economic and social research and then develop more effective plans for providing better medical care to all segments of society, the vacuum will be filled by a series of legislative acts some of which necessarily will be politically motivated. Private support will determine in great measure the pace with which medical schools advance and whether they will move forward as self-determining institutions.

IT SEEMS TO ME ESPECIALLY important that the Harvard Medical School retain control over its own destiny because in many ways it is the most influential school in the nation. (As an alumnus of the University of Chicago, I can say this with some impartiality.) Harvard has an unrivaled capacity to produce teachers of medicine, and this is a vital point as there is already a serious shortage of teachers to man the new and expanded medical schools being established to meet the increasing shortage of physicians. The Harvard Medical School is the leading producer of faculty by a wide margin. A quarter of all the full-time teachers of medicine of professorial rank in the nation's 93 medical schools owe at least a part of their education to Harvard or to one of our affiliated hospitals. Twenty-one of these schools' deans are Harvard-trained. Some 2,000 of the approximately 6,000 living graduates of the Harvard Medical School are involved to some degree in the teaching of medicine. The impact of the School on medical research and patient care is world renowned.

It is my hope that Harvard will also play a leading role in a searching examination of community problems preparatory to formulating appropriate solutions. Greater cooperation among physicians, economists, sociologists, and behavioral scientists should lead to development of the background knowledge necessary to deal creatively with such problems as the economics and distribution of medical care, the growing importance of preventive medicine, the changing function of hospitals. In this connection we intend to press forward with plans to bring together six specialty hos-

pitals affiliated with Harvard into one hospital complex adjacent to the Medical School. Establishment of a Center for Research and Training in Human Reproduction and Reproductive Biology also has high priority. This Center will function as an interdepartmental enterprise, bringing into one facility scholars with differing backgrounds and skills, to focus on the physiology of human reproduction. In addition to emphasizing research, the laboratories will serve as a training center for future investigators in this field.

The Medical School is also in critical need of two new science buildings to provide the additional space that is essential to improve the curriculum and increase the size of the pre-doctoral and post-doctoral student body. The curriculum must be reevaluated on a continuing basis. It has become apparent that the sheer mass of scientific knowledge which must be presented to medical students is so great that a much more searching examination must be made of our philosophy and method of teaching, particularly during the first two years. This process has begun. As decisions are made and changes instituted, they will, of course, be reported to the Alumni, as will the details of other plans taking shape.

Thus, with the School now resting on a sounder financial basis, and having gathered new strength in the basic and clinical sciences, the Faculty is prepared to confront the problems and opportunities of the future in a way that has not been possible in the past. For your part in helping to achieve this growth, the Faculty is deeply grateful.

IT WAS LAST MARCH THAT Langdon Parsons, Director of the Harvard Medical School Alumni Association, invited me to address a meeting of your Alumni Council in order to acquaint them with much of the foregoing and also to propose to them the formation of an important new Committee on Resources at HMS. The Council, after listening all day to a detailed account from Henry Meadow, Associate Dean for Financial Affairs, Bayley Mason, Assistant Dean for Resources, and myself, were helpful and enthusiastic about our proposal of the Committee. They gave it their unanimous support.

Since that time plans for the Committee have been formulated and because the role we hope the Alumni will take re-

garding the Committee is an important one, I am glad to have had this opportunity to give you some background as to what led to its formation, what it hopes to achieve and what it is not.

To deal with the last point first, the Committee on Resources does not pre-empt another major capital campaign.

Instead its formation should be considered as being a natural transition from the success of the Program for Harvard Medicine to a way of meeting our present and projected needs. Although the Program achieved its aims, it was only the first step, and the impetus gained through it is something we cannot allow to fade away. Now, faced with the necessity for continuing our development, we must search for new sources of financial support. It is towards this end that the Committee on Resources has been formed.

It will be primarily an advisory body, responsible directly to me. Its function will be **to assist in identifying and developing** various sources of private financial support. It is, I feel, important that you understand that this is the role all Alumni are being asked to take. It is one in which you can be of tremendous help. We are, therefore, extremely fortunate in having two distinguished Harvard Alumni to lead the Committee: John P. Merrill '42 and George G. Walker, Harvard College '24. As co-chairmen they will share the responsibility of making a highly selective effort to raise capital resources and major current use funds.

On May 27, 1966, the Alumni Council approved "full partnership of the Alumni" with the lay leadership of the University, and it was agreed that membership of the Committee on Resources should be composed equally of Alumni and friends of the Medical School drawn from Boston to San Francisco, from Chicago to Dallas or wherever else private support will be sought.

It will be one of the over-riding concerns of my administration to maintain a healthy balance between Federal and private financial support. A corollary of this is the preservation of harmony between the scholarly aims of the institution and its obligation to meet the demands of society.

The decision made by the Alumni Council reflects, once again, the thoughtful consideration of a responsive, powerful Alumni—which I know you to be—a group justifiably known as "leaders in medicine."

Numbers Please

by Ben Eiseman '43A
and
Frank C. Spencer, M.D.

SIMPLE MATHEMATICS

dictates that even during a quiet year there will be a turnover of 6.2 Chairmen of Surgery in the existing 89 medical schools in the United States. The mean age of appointment, according to the roster of the Society of University Surgeons was 41.33 years. Although the usual retirement age is 65, the anticipated 23.66 year mean span of office (half-life 12.8 years) is skewed by several factors. There is a tendency in this modest group for some surgical giants to hang on beyond the legal limit and after recovery from their first two or three minor strokes. This factor is more than compensated by the steep decay curve for academic surgical leaders. Chairmen of surgery are at high risk quite apart from the slings and arrows of ordinary misfortune. With administrative tenure lacking, some frustrated medical school deans are notorious in their use of surgical chairmen, as younger siblings treat stray cats, or captured flies, and as a result, 2.2 surgical chairmen have on the average been removed annually during the past 5 years for what euphemistically is termed "other reasons." The actuarial rates the vulnerability of a surgical chairman on a par with the point-man in a Marine combat platoon.

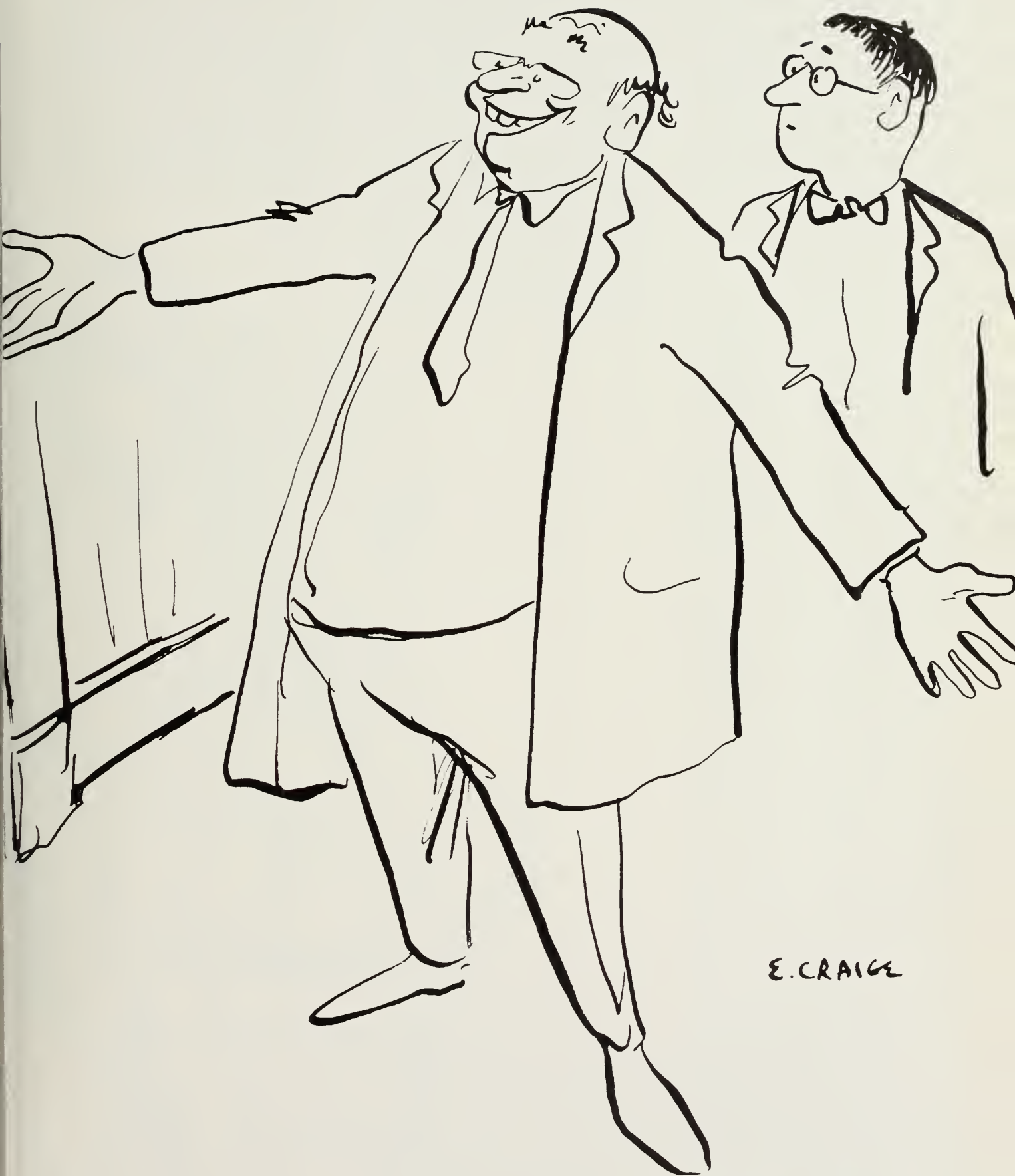
A recent survey in six sample medical schools demonstrated that an average of 4.1 candidates were interviewed by each search committee.

Six and two-tenths positions were each surveyed by four and one-tenths candidates. This means that 25.42 visits are made annually by surgical chairman candidates. Some, at least, may profit from knowing what questions to ask and where to look for meaningful data.

There is reasonable personnel overlap in this group, as candidates known to be "hot" are wine, dined, and inspected by

A knowledgeable triad combined to bring you "Numbers Please." Dr. Eiseman is professor and chairman of the Department of Surgery at the University of Kentucky College of Medicine. Dr. Spence, a graduate of Vanderbilt University '47, was professor of surgery in Dr. Eiseman's department until early this year. He is now professor and chairman of the Department of Surgery at New York University Medical School. Dr. Craig, no stranger to HMAB readers, is professor of medicine and chief of cardiology at the University of North Carolina School of Medicine.





"An oversized broom closet

which the Dean assures him is convertible to an animal OR."

more than one institution. A sufficient number of surgeons, however, annually are asked to consider an open chair to warrant a survey of the most efficient means of evaluating such an important academic post. The refreshing American tendency for picking young men for departmental leadership makes such guidelines of particular importance.

Fresh from triumphs in the operating room alongside the gleaming electron microscope, or newly emerged from a hyperbaric chamber, some of these candidates are remarkably naive concerning the ground rules employed in the academic arena. Though his curriculum vitae provides padding for ordinary shocks, he usually is in no way prepared to evaluate the enormous complexities of a new department. Trained in the shadow of a surgical giant, the candidate chairman, more than likely, has been largely shielded from the harsh facts of academic reality.

The young candidate on his vital visit thus faces a two-or three-day ritual for which he is unprepared. The interview characteristically is performed with the formalism and preciseness of a 17th century minuet. The candidate must waltz with social grace along the ill defined line of polite etiquette while burning to pace out dimensions of assigned labs or to ferret out the exact cage capacity of the oversized broom closet which the host Dean assures him is convertible to an animal O.R.

The *incognicente* is overwhelmed by the endless series of 30-minute interviews with key faculty personnel. Dozens of general educational topics such as the role of surgical research, trends in post-graduate education, and the future of surgical practice, are discussed over endless cups of coffee by day, and more potent stimulants after sundown. Unless he is careful and reasonably well organized, the candidate gives copiously of himself but completes his visit having little objective data on which to judge the institution seeking his services.

As with any site visit, this all important trip is productive in direct proportion to the homework and preparation which precedes it. The following comments are designed to provide a framework for the young candidate considering a surgical chair.

ONE OF THE MORE COMMON ploys used by the home team in explaining previous lack of local progress in surgery is a disparaging reference to a

previous lack of leadership or spirit of intellectual inquiry. Since most search committees, for inexplicable reasons, pointedly omit surgeons from membership, these slighting references are usually made with a broad down-stage wink.

No one minimizes the importance of leadership, but a Model T Ford cannot be converted into a Ferrari merely by switching drivers. Such mundane factors as horsepower, gear ratio, and fuel consumption are of critical importance, and their evaluation can be reduced to numerical quantification. So too, can many factors surrounding a department's potential, and it is the duty of the candidate to derive as much objective data as possible from his visit. He may choose to be

philosophical and coy during his first visit but when the courting gets serious he had better have a notebook and pencil ready.

There are at least six areas where numerical evaluations are possible:

1. Faculty
2. Departmental Budget and Financial System
3. Beds and Operations
4. Assigned Departmental Space (ft²)
5. Curriculum Time



“and more potent stimulants after sundown.”

6. Relationship of Hospital to Medical School

The well organized candidate will have a chapter of notes on each.

1. Faculty. There are certain areas of general surgery that demand coverage regardless of the size or financial structure of the Department. They are: cardiovascular; endocrine; gastrointestinal; fluid and electrolyte; pediatric surgery; plastic; trauma; transplantation; and tumors. By whatever adminis-

trative and budgeting device, each should be covered for teaching service and for investigation. A faculty of four or five general surgeons cannot possibly be productive in every area of specialization. Budgetary support must be identified for each. Existing personnel must be interviewed, and their curriculum vitae, publications, aims, ambitions and potential, personally assessed.

2. Space. Departmental Chairmen, as well as NASA, are involved in Space Medicine. In general, 1500 ft² is a generous allotment for the office, secretarial space and laboratory for each full time faculty. Space is a fixed item, and the candidate should, when the time comes, talk room numbers and square feet with

the Dean, marking out with indelible red pencil that part of the floor plan to be allotted to him. Frontiers thus exactly defined guarantee subsequent friendly academic neighbors. It is the undesignated geographic borderland that invites invasion into a power vacuum—a principle long recognized in International Diplomacy.

Centralization of space is important. A Department of Surgery requires space for teaching, patient care, research, and offices for faculty and staff. Effectiveness, productivity and efficiency vary in geometric proportion to proximity. Dispersion may be indicated under nuclear attack but in the hurly-burly of close-in academic ambush and guerilla warfare, the enclave has merit.

3. Beds. Beds are the currency of evaluating clinical teaching and research potential and their quantification is essential. This requires identification by specialty as well as by financial designation. Let not the potential chairman responsible for resident training confuse large numbers of private beds over which he has little control with a much smaller, tight ward service. A reasonable rule of thumb maintains:

a) Each Chief Resident requires approximately 20-25 beds. (Degree of indigency alters this absolute value.)

b) Each full time faculty member requires at least 5-6 beds for his personal use. (With an average patient stay of 8-9 days, he can thus personally perform 150-200 operations per year.)

Supporting data as to the adequacy of clinical material can be found by personally checking the length and nature of the hospital's waiting list for both ward and private admissions. The O. R. schedule, lists of procedures performed by varying levels of residents, outpatient and emergency room visits, and other support-data, can be obtained, prior to the visit, from homework, discreetly performed with the Annual Report.

Utilization of the existing beds must be evaluated by determining the annual operative load. Ten operations a day totals 2,500 procedures annually. Operative totals should be broken down to determine what percent are performed by residents, faculty and private surgeons. The more difficult it is to obtain these precise percentages from the host institution, the more revealing they are likely to be to the critical reviewer.

4. Budget. A Department of Surgery is a big business, a fact frankly unrecognized by those not intimately involved in





“...the enclave has merit in academic ambush and guerilla warfare.”

academic medicine. Gross income frequently exceeds one million dollars if all patient, grant, and hard money from medical school sources are included. The financial statement of an enterprise of this magnitude cannot be digested in one cursory glance.

The aspiring candidate, as soon as possible, should seek the official most knowledgeable in budgetary matters and carefully go over the books. Every conceivable minor faculty potentate will be included on the candidate's agenda but seldom will the key figure—the budget man—voluntarily be made available. Until a prolonged and frank discussion with the comptroller has been completed, negotiations are merely on a social basis.

Departmental economics is a specialty comparable in complexity and requisite years for qualified training with advanced cardiovascular surgery. No instant knowledge or cram course will suffice but a few areas of factual inquiry can be identified.

An inexperienced candidate may be put off by the announcement of a very generous “total departmental budget.” The “pro” will not be diverted by such blandishments and will politely ask for details.

Starting with numerically valid university and medical school budget figures, he will work down to his own and other departmental budgets. At this point, the talk gets serious.

Despite all administrative protestations to the contrary, the budget must be dissected by sources of income. To accept the premise that there is no such thing as “hard money” is to sell your departmental financial birthright.

Hard money consists of funds committed by the university to the department in contrast to money raised by grants or patient income. Whether the Dean raises such hard money from State legislature, endowments, church, or city is immaterial. Income from teaching grants, research grants, departmental

endowment, and return from private patient fees is important to identify, but the committed hard money budget is the core to the financial structure.

The single most controversial factor in medical school and department of surgery relationships is the method of managing fees paid to full time surgical faculty. As such, search committees in their dealings with potential candidates characteristically avoid clear-cut reference to this issue much as some other groups avoid mention of family planning. They know it's going on, they know everyone is vitally interested, but they hope by obfuscating the issue, everything will turn out all right. Besides, in polite society, it is not nice to talk about such things among colleagues.

The surgical chairman candidate can play this faintly amusing game for a time but had best come to early detailed documented grips with the issue. The academic surgical graveyard is filled with the bones of surgeons who either

did not read the warning signs, or did not have this aspect of the job well understood and documented in advance of a move. There may be more important aspects in considering a surgical chair, but as yet they have not been universally recognized.

The candidate must judge for himself the adequacy of the system—but at least he must have the hard facts in hand.

The financial ground rules must be spelled out in detail for disposition of patient fees for full time, part time, and volunteer faculty. If there are any limitations involved—specific percentage return to university, medical school, department, division and to the surgeon—they must be numerically documented. If some sort of income overage system is operative, then numerical quantitation of income during previous years should be inspected. This will result in meaningful ratios as to the amount of department budget derived from hard money, soft money and patient fee income.

Another budgetary booby trap for the careless or unwary is the matter of house staff and secretarial support. The salary of such hospital personnel, usually running into six figures, must not be confused with medical school departmental activities. Budgetary clarity is only achieved by a line item personnel review, because some secretaries clearly perform hospital and other medical school services. The fewer the secretaries funded from grants and from private patient sources, the sounder the department's financial structure.

5. Relationship of Hospital to Medical School. Another area which has proven critical for surgical chairmen is the administrative relationship between hospital and medical school. Although budgetary ischemia may be the precipitating cause of academic gangrene, chronic obstructive hospital control usually underlies the disorder. This dreaded malady has stricken some of our best.

Although not subject to numerical evaluation, responsibility and authority can easily be diagrammed by using standard administrative techniques. The candidate should ask the Dean to fill in the boxes and draw the lines in a diagram depicting the table of organization. Team spirit and shared responsibility is essential to make an organization function, but it must not cloud the fact that efficiency requires clear lines of responsibility and authority. Beware if the two do not coincide.

Pecking order is as important in the hospital as in the barn, and relationships must be crystal clear between the chairman of surgery, the hospital administrator, the chief of nursing services, and the board of trustees of the hospital. Clearcut lines of authority also must be defined for both the University and any other affiliated hospitals.

6. Curriculum Time. The regrettable recent tendency to disparage surgery in undergraduate teaching has resulted in a concerted effort to minimize its assigned curriculum time. Based on the fallacy that surgeons are mere technicians, there are those who would relegate surgery merely to a postgraduate discipline. The candidate chairman must be prepared for such an onslaught carried out in the false name of pedagogic progress. Curriculum time for the department of surgery can be defended by returning to the precept that a surgeon is the best qualified expert in those diseases best treated or investigated by operative means.

The candidate should systematically review the curriculum hours allocated to

surgery for each medical student year. Such curricular opportunities should be broken down into lecture time, shared or joint responsibility with other departments, and finally, the all-important clerkships, when the student is solely the surgeon's responsibility.

The Intangibles: No plea for quantification and objectivity is valid if it leaves the impression that any situation as complex as a community of scholars can be solely evaluated by numbers. The potential of an institution ultimately lies in those who populate it. The surgical candidate for chairman will inevitably develop his own opinions of his potential colleagues in the community and within the rest of the university.

A major academic move is comparable in importance to a decision for marriage: decision cannot be reduced to total computer analysis—but certain basic numerical measurements are of enormous importance in arriving at a valid judgment and prediction of success, future happiness and productivity.



“but
seldom will
the key figure
—the budget man—
voluntarily be made available.”



A Physician's

Glimpse of Siberia

by Oleg Jardetzky, M. D.



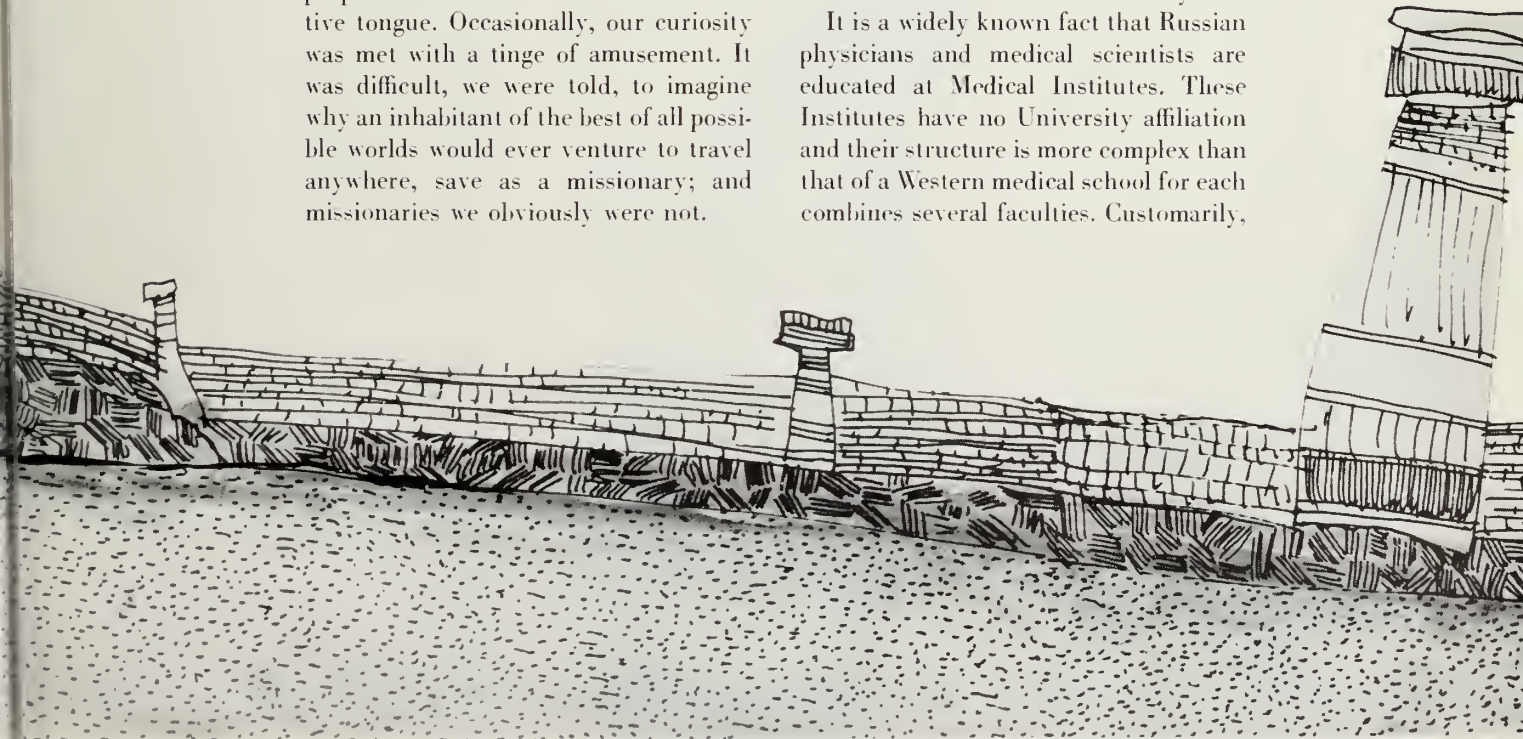
*Siberia is the land of boundless promise
to those who choose it —
and a wasteland shrouded in bottomless despair
to those for whom it is chosen.
In this embrace of paradox,
it reflects its proverbial Russian spirit.*

To most of us in the West, Siberia is simply terra incognita. Hence, with much curiosity and only a few preconceived notions my wife and I approached its Eastern borders enroute from Tokyo to England in September, 1965. We were not complete strangers to things Russian, as memories of the Biochemistry Congress in Moscow were still fresh. We were, however, given many hints of the trials which awaited us on our planned journey on the Transsiberian Railroad, and at times we felt that we should have come somewhat better prepared.

Our fears were allayed before long. We encountered neither privation nor lack of humor. We found that restrictions of freedom arose in direct proportion to the ostentation with which one tested their existence and in inverse proportion to one's command of the native tongue. Occasionally, our curiosity was met with a tinge of amusement. It was difficult, we were told, to imagine why an inhabitant of the best of all possible worlds would ever venture to travel anywhere, save as a missionary; and missionaries we obviously were not.

Our first opportunity to encounter our Russian colleagues came when we boarded the three year old, 5200 ton vessel s/s *Baikal*, which carried us from Yokohama to Nakhodka, a tiny commercial port about 100 miles east of Vladivostok. On board were a number of Russian psychologists, pharmacologists, chemists and cyberneticists, and the vice-rector of the University of Moscow as well; all returning home from scientific meetings in Tokyo. We met Professor Simon Miroyan of the Department of Pharmacology, Yerevan Medical Institute, and he was a most charming companion. He gave us our first introduction to the design and realities of medical education in Russia. With him we had the first of several memorable debates on the philosophies of professional life within the structure of another society.

It is a widely known fact that Russian physicians and medical scientists are educated at Medical Institutes. These Institutes have no University affiliation and their structure is more complex than that of a Western medical school for each combines several faculties. Customarily,



there is a Faculty of Therapy, Sanitation and Hygiene, Dentistry, and Pharmaceutics. All of these have a Western counterpart. And on a par with our medical schools, there is a Faculty of Pediatrics, Obstetrics and Gynecology, and, in the near future, there may be a Faculty of Neuropathology and Psychiatry. Specialization begins at the very outset of clinical training and each subject is taught with a particular application of medicine in mind.

Each Faculty consists of departments, referred to in the British manner as chairs. Each department governs its own admission policy, program and student body. A reasonable estimate of the average enrollment in each of the Faculties is 600, which, with a six year program, averages 100 students per class, and 3,600 or more per Institute at any given time. Some chairs, particularly those in the basic sciences, have responsibilities to more than one Faculty, which correspondingly doubles or triples their already heavy teaching load.

The Institutes are subordinate only to the Ministry of Education which approves their budget, all appointments and degrees. In addition, there exists an intricate web of planning and reviewing committees which coordinate their activities with those of the USSR Academy of Medical Sciences. Yet within this elaborate framework, each Institute enjoys a remarkable degree of autonomy, which is frequently reflected in its curricular detail. The chair of pharmacology in Yerevan, in keeping with local tradition, places great emphasis on the central nervous system; the chairs in Khabarovsk and Vladivostok stress chemistry, for their interests lie in the exploration of the medicinal properties of Ghien-Hsien and other representatives of the abundant but little-known native flora.

OUR first visit to a Medical Institute took place in Khabarovsk, named after the former Siberian prisoner, Khabarov, who, with his followers, founded the first settlements in the region around 1845. We were surprised to find notices on the bulletin boards announcing deadlines for scholarship applications, but we soon discovered that scholarship support is not at all universal and is based as much on need as on merit. It is true that tuition is nominal, but the proof of need required to obtain assistance for living expenses is quite stringent.

We were less surprised to see announcements of entrance examinations,

for we had heard about the differences in admission procedure. Ten or eleven years of primary and secondary schooling are the customary preparation for admission, but the standards are set by the examination alone. To those whose background is insufficient, special preparatory courses are available for an additional year or two. After looking over the examinations, we were surprised that only a small fraction, some 20 per cent of those admitted, take the additional courses. Calculation of the equilibrium constant for a chemical reaction, solution of a simple differential equation, constructing a diagram of the optics of a microscope or a brief discourse on the evidence for the evolution of species are typical questions. The average age of admission is 18-19, and with a six year course and no college preparation, one might expect marked differences in the program. But on closer inspection, the similarities outweigh the differences. Physics, biology and chemistry are by and large completed in the

first year; four years are devoted to the formal presentation of medical subjects and the final year is the clinical apprenticeship, at the end of which the graduate receives a physician's diploma. There is no doctorate of medicine and no internship after graduation. In essence, the internship is served in the last year.

Interspersed with notices concerning scholarships, examinations and schedules, there were many notices announcing extra-curricular activities, mostly in the form of informal clubs (Ruzhki). These clubs pursue anything from chamber music to entomology, genetics, psychiatry, embryology or political economy; auxiliary courses in Latin, as all their prescriptions are still written in Latin, and Russian spelling; service projects, stamp auctions and student newspapers.

Perhaps our unannounced visit to N. K. Fruentov, the incumbent of the Chair of Pharmacology, was not in keeping with the best international academic protocol. But we were not made to feel the guilt of our transgression, and during the next two hours we were given a fair glimpse of the scope and caliber of the activities at the Institute. The pharmacology course was impressive and refreshingly modern in its concept. It proceeded from the physico-chemical principles governing drug action, to well understood cellular poisons, to membranes, specialized cells and organs, and then to less well defined pharmacological phenomena. It was clearly aimed at minds well prepared to progress from the conceptually simple to the conceptually complex, and it was free from the crippling traditional notion that biology lends itself to the Euclidian approach of the deciphering a phenomenon by simple repeated inspection.

Before we left Khabarovsk we had time to wander through the town and we were intrigued to observe bee-hive hairdos on the women. We were surprised to see the reputedly grim Siberians indulging in cheerful gossip as they sampled the products of the local culinary school, and delighted to discover that the taste of the candy, "Happy Childhood" is distinctly superior to that of "Bear in the North."

That same afternoon we boarded the train for Irkutsk. We had just settled down for a glass of tea when the train halted in Birobidjan, and we were joined by a young man bound for Arkhara. As fate would have it, he introduced himself as a feldsher: a graduate of a medical



educational institute whose program is halfway between that of a school of nursing and medicine proper. He was an ardent chess player, and over a few rounds he gave us a partial account of his life. He was stationed in a small settlement in the Jewish Autonomous Region and ministered to the ordinary medical needs of 30–40 families. It was his task to sift out common colds from incipient cases of pneumonia, and sprained ankles from tibial fractures; to administer gamma globulin for the prophylaxis of measles, and chlorpromazine for emotional upsets; to decide whose swelling could be dismissed as a lipoma, and who was to be examined at a clinic for possible malignancy. It was also his duty to make routine visits to patients under a physician's care when no more than a routine visit was needed. The prevalent practice in the region is to have three or four feldshers working with each physician, whose practice is then limited to the less obvious cases in a population of about 500–800.

It is not easy to get accurate statistics on the doctor-patient ratio, or, for that matter, on anything else. This is not for any excessive secrecy, but for a reason put to us with a sigh—"coordination of the country as a whole is a slow process and by the time we get a set of numbers, we know from checking our own contribution that there must be a better set of numbers underway." With this in mind, we accepted some data on epidemiology. Especially prevalent seem to be the non-infectious gastrointestinal ailments—ulcers, carcinoma and gallstones. Watching one native after another average two bottles of beer and a pint of wine or vodka for breakfast, with no visible side effects, makes one wonder how many of the intestinal troubles are due to the diet. Pneumonia and lung cancer are also frequently mentioned, but cardiac, circulatory and infectious disease much less so. My only first hand experience was with the Siberian common cold. It lasted 48 hours, with a high fever, and broke in an almost classical crisis overnight.

OUR visit to Irkutsk began on a rainy morning. There was not much point in trying to sightsee, and the Intourist office was only too glad to arrange a visit to the Medical Institute for the afternoon. It was the only arranged visit we made, and perhaps this was the reason that the initial reception in the

office of the vice-rector of the Institute, Professor Melnikova, was cordial but formal. But as we moved on from polite generalities to vital specifics, the tinge of strain succumbed to traditional Russian hospitality, and it was well into the evening hours before we returned to the hotel.

One of the questions that still remained in our minds was the fate of the young medical graduate. In outline, it is not very different from that of our own. The majority will accept an assignment to a "medical point," a physician's office equipped and maintained by the state, sometimes attached to a clinic, and sometimes, almost literally, out in the field. This may be either a two-or-three year tour of duty, or a career.

As a career it is not uncomfortable. The working hours are less than 40 a week, at a salary of 100–300* rubles a month, with liberal vacation allowance. It is not eagerly sought after though because of the limited chances of intellectual growth. The more desirable posts are those attached to hospitals, with opportunities for specialty training, the formal part of which lasts two to three years. Some students compete for such assignments immediately upon graduation, and, if successful, remain on a hospital staff for life. Some elect a teaching and research career. This group is required to complete a three or four year Aspirantship in a teaching department and present a thesis for the degree of Candidate of Medical Sciences, which in scope and spirit, has its counterpart in the Western Ph.D. The Doctorate of Medical Science, like all Russian doctorates, is a higher degree much like the British D.Sc. It is seldom attainable before the age of 35–40 and is based as much on the candidate's scientific productivity over a 10 year period as on the dissertation and its public defense. The exceedingly rare distinction of having a doctorate awarded for a candidature thesis is, of course, much treasured.

The defense of a thesis and most undergraduate examinations are oral and open to the public. In fact, most students attend the examinations of their colleagues in order to clarify their own thinking on the important issues in a given field.

The principal reasons cited for retaining the oral examination are two: first, the student's ability to arrive at an answer is not the only relevant criterion

in the evaluation, but his method of doing so is of equal importance; second, perpetual testing of everyone's knowledge and power of reasoning in open court is essential for the development of intellectual integrity and the discouragement of one-upsmanship.

It is quite interesting that the prevalent encouragement of competition goes hand in hand with an equally prevalent discouragement of aggressiveness. This seems paradoxical, because we have come to equate aggressiveness with success, and success with excellence. It takes some small effort to recognize that the language used elsewhere is different not only in sound, but also in concepts, and that such premises are far from having general acceptance. The accepted standard of excellence in the Russian Society is the mastery of the largest share of the most complex attainments of the human race. Such excellence need not be exclusive, and superiority over one's fellow men in any regard is irrelevant to it. Hence, the only valid form of competition is competition with yesterday's own self. Thus there is insistence on absolute standards, the rejection of ranking, and condemnation of ostentatious superiority.

There is a temptation to view this as so much collectivist doctrine which fails to recognize human nature in its true light. Yet without arguing the nature of human nature, one is forced to reject the temptation on historical grounds. Records of Russian preoccupation with solidarity long antedate the Marxian era, and the idea of non-selective excellence is very much in keeping with the traditional Da-Vincian aspirations of the Russian intellectual.

There is great emphasis on hygiene and preventive medicine in Russia which is in line with the systematic cultivation of foresight on a massive scale. Perhaps as much as three-quarters of all effort is devoted to the dissemination of knowledge. Again, one may be tempted to write this off as current political doctrine. But one wonders why a particular doctrine takes such a strong hold on one historical soil and not on another.

Whatever the contributing factors may be, surely one of them is a deep commitment to the philosophy perhaps best expressed by Oliver Wendell Holmes—that the greatest need of the world today is education in the obvious, rather than investigation of the obscure.

One wonders whether the dominant trend in medicine is, as we put it, disease

* Approximately \$112–\$336



oriented or patient oriented. One gains the impression that it is decidedly the former. The patient receives care for an ailment, and enough information to sense the rest of his problems. The responsibility for formulating and having them dealt with remains very much his own. We encountered many opinions, and some misconceptions, about American medicine. For instance, they find it hard to believe that some of the best medical care in the States is given to charity patients.

THE state of Russian psychiatry was to us of rather special interest because every society is a kind of Skinner box and one might expect its peculiarities to

be most vividly reflected on its psychiatric wards. And indeed, in no other branch of medicine, did the differences reach as deeply.

An enumeration of these differences, not to speak of an analysis, would easily amount to a treatise in comparative cultural anthropology. In general terms, however, they arise both from differences in practical problems and from differences in the basic intuitive assumptions about the nature of human life.

Many of the problems facing American psychiatrists never come to the attention of Russian psychiatrists. They are dissipated in the multitude of intimate personal friendships, cemented from childhood by perpetual wrestling with psy-

chological, moral and social problems. One literally hears them dissipated in streetcars and busses, in theater halls, in restaurants, in parks, in shops. The habit of freely sharing one's feelings and thoughts with friends and indulging in soul-searching almost hour-to-hour is widespread and friendships are close and mean much. Their cultivation may not contribute much to efficiency, for it interrupts the sale of merchandise just as much as the booking of plane reservations, but it contributes perceptibly to the spread of common sense, wisdom and mental health.

The cases which do come before a psychiatrist are, for the most part, severe, and verbal methods of treatment

are not of much use. As one Russian psychiatrist put it: "You can talk a man out of resenting his mother for strictness in toilet training, but not out of resenting the Germans for raping and burning his mother alive in front of his eyes." Indifference to psychoanalysis stems not so much from lack of acquaintance, as from the recognition of its limited relevance to the problems at hand. The relevance of Freudian insights to American problems is hardly ever questioned, for the American is seen, on the authority of Hemingway, Tennessee Williams and Theodore Dreiser, as being ruled by the conflict between constitutional license to claim his omnipotence, and the nonverbal fundamentalist rigidity of his own puritanical kin.

Even on cursory contact one can sense among Russian psychiatrists a preoccupation with physiological rather than psychological mechanisms of mental illness. There is a trend to consider the causes of a given derangement as not strictly relevant to one's ability to repair the deranged mechanism. There is also a belief that ailments reflecting damage to the same mechanism should have a common cure, regardless of the cause. It is in the sense of this philosophy that Russian psychiatry is derived from the writings of Pavlov, rather than in the sense of any concrete use of conditioned reflexes.

As the train rolled across the Urals, the reality of Siberia merged into the more familiar reality of Odessa, Kiev, Moscow and Leningrad. And, as in every journey's end, it brought comparison and reflection, for one can never cease to be stunned by the whimsical course of human progress which brings different trends to the foreground in different places at any given time.

Anywhere one finds the direction of the development of an efficient society and that of the growth of an individual at right angles to each other, one might expect that the direction of human progress lies midway between them, but in fact, different societies err on different sides of it. It is plain that the Russian way of life could be greatly improved by a wider use of vernier calipers and the American way by a greater cultivation of wisdom. It is equally plain that there are potent forces at play in each society seeking to correct its own historical errors. Were history to run on perfect insight, such forces need not lead to conflict. But, in fact, they do lead to conflict, for ignorance and lack of

feeling for the realities of another society are fertile soil for strife. The wounds of such conflict are easily inflicted and difficult to heal. But in the days of tension we can take courage from encounters which remind us that physicians across the world share a bond which is meant to transcend the currents of history. It is their calling to prevent, as well as to cure, the ills of humanity by seeking to enlighten and humanize mankind.

Dr. Jardetzky is assistant professor of pharmacology at Harvard Medical School and consultant in pharmacology at Massachusetts General Hospital. He has just completed a round-the-world trip which began, as his article indicates, in Japan and the U.S.S.R., then on to Cambridge University where he took a year's sabbatical.



ALONG THE PERIMETER

HMS Has a New Academic Department

There is a new academic department at the Harvard Medical School. On July 20, Dean Ebert announced the establishment of the Department of Neurobiology under the leadership of Dr. Stephen W. Kuffler, Robert Winthrop Professor of Neurophysiology and Neuropharmacology.

The Department will serve as a focal point, at preclinical and postdoctoral levels, for research and teaching ranging from subcellular physiology, anatomy, and chemistry through cellular and integrative levels. It will encourage disciplines such as microbiology, genetics, and developmental biology so that their impact may be felt on neurological problems.

Dean Ebert pointed out that in addition to its research potential, the Department will play an important role in teaching and advanced training. It will provide a broad-based program of instruction to students in their preclinical years and will be one to which postdoctoral workers can turn for advanced training. The goal will be to train a new generation of workers who are at home in several different areas of nervous system studies.

Dr. Kuffler, who will head the new Department, has been a member of the Faculty since 1959. His research has been concerned with understanding the function of individual cells of the nervous system and how these units interact with each other to produce more complicated neural behavior.

He has made basic contributions to the study of the transmission process by which the coded information is handed on from one nerve cell to another, or from nerve to muscle. His investigations of the physiology and chemistry of the transmitting agents and the means by which these agents stimulate or inhibit nerve cells are renowned. The significance of the transmission process in the central nervous system is that the information is not handed on unchanged. Each new cell receives impulses from many others and in this way, information from different sources is collated and analyzed.

Macy Foundation Gives Grant for Medical History Studies

A \$60,000 grant from the Josiah Macy, Jr. Foundation of New York is enabling Harvard Medical School to inaugurate a program in The History of Medicine. The funds will be allocated over a three-year period.

The Medical School will use the developmental grant for: a lecture series; stipends for visiting professors and lecturers; the organization of elective seminars for faculty and students; research of faculty members and medical school students; and for the training of a librarian in the handling of historical materials in the medical sciences.

The focal point of the initial program will be the Countway Library where the collection of historical materials has been described as "the single greatest resource for studying the history of medicine in the country," by Dr. I. Bernard Cohen, Professor of the History

of Science at Harvard.

Dean Ebert, in announcing the grant, said that the ultimate goal of the Medical School is to establish a Department of the History of Medicine.

"In this era of rapid socio-economic change and of accelerating scientific and technological advances," he said, "university medicine must grasp the leadership in meeting society's rising demands for better health care. Medical education cannot assume this responsibility unless there is a keener understanding of the social, economic, philosophical, legal, theological and scientific forces that affect the health of individuals and society. It would be the basic purpose of a Department of the History of Medicine to study these forces in their historical evolution up to the present day, thereby giving perspective to current problems and future planning."

Dr. Kuffler





Federman Appointed Assistant Dean for Continuing Education

Daniel D. Federman '53 has been appointed Assistant Dean of the Faculty of Medicine for Continuing Education. He succeeds Eugene C. Eppinger '30, formerly Assistant Dean for Courses for Graduates.

Dr. Federman is associate in medicine at the Massachusetts General Hospital. He has long been interested in the continuing education of the physician and organized and administered the post-graduate medicine course at the Hospital. He has also served as coordinator for the second-year teaching in medicine at Harvard Medical School.

This tree, a gift to the Countway Library from the Greek Government, is no ordinary one. It was grown from a slip of the plane tree under which Hippocrates is said to have taught. ("Ye Gods! annihilate but space and time . . .")

Haddon Directs Traffic Safety Agency

Automobile owners expect the cars they drive to be safe. To insure this expectation, President Johnson recently signed new Federal legislation establishing mandatory Federal safety standards for motor vehicles and tires. At the same time, he signed another bill providing financial incentives for states to enact comprehensive traffic safety laws.

This new legislation will be administered by the National Traffic Safety Agency which is set up within the Department of Commerce. Head of the Agency is William Haddon, Jr. '53.

Dr. Haddon, nationally recognized as a traffic safety expert, has been a pioneer in approaching the automobile accident as a problem in preventive medicine. He

believes that to suggest that vehicle design is unimportant in a crash because it is the driver who causes the crash, "is not only illogical nonsense, but destructive of the great progress in crash protection which we, as a nation, should have achieved many years ago."

Until now, Dr. Haddon said, "we have been content to ship ourselves and our loved ones in packages deficient in the very characteristics we insist on when we ship teacups."

Dr. Haddon was formerly director of the New York State Health Department's Division of Chronic Disease Services. He was also director of the Driver Research Center of New York's Health and Motor Vehicles Departments.

Vanishing Landmarks

It has come to our notice that Edward Jenner's house in Cheltenham, England is about to be demolished in the process of a redevelopment scheme. It is hard to believe that such an important landmark in medical history will be allowed to vanish with no word of protest from learned opinion the world over. It was at this house, 8 St. George's Place, that the real organization of mass vaccination was initiated and it was from here that the movement spread its influence to all corners of the earth to materially change the social history of the world.

It is understood that the house has been allowed to fall into a derelict condition and that the local authorities, apparently insensitive to its historical value, are interested only in widening the street to make easier access to a planned parking lot. The fact that the reason for the proposed demolition is so relatively trivial is perhaps the soundest reason for attempting to save it. An offer to buy the property, which as real estate is virtually worthless, would seem the obvious course. It is also obvious that medical circles and society in general, are probably unaware of the proposed demolition. If Jenner's house is to be saved, it is for them to speak up quickly and decide how to do it.

Readers may like to know that the HMAB recently received four awards from the American Alumni Council's "Annual Publications Competition." This competition attracts hundreds of top graduate and undergraduate alumni magazines in the U.S. and Canada. For the first time HMAB was recognized in four areas. Our awards were:

BEST PHOTOGRAPHS OF THE YEAR: For cover photograph of former Dean George P. Berry standing in the stairwell of the Countway Library. [Summer, 1965.]

SPECIAL RECOGNITION: For the article, "Jack and the Beans" by George E. Vaillant '59. [Fall, 1965.]

EDITOR'S COMMENT & OPINION: Distinctive Merit Award for the editorial, "The Thing About Yaws . . ." by Robert M. Goldwyn '56. [Spring, 1966.]

ALUMNI CONTENT & COVERAGE: Honorable mention for over-all excellence. [Spring, 1965 through Spring, 1966.]

^d**Abbatiello, Vincent J.**
Westbury, New York (Cornell Univ.)

Ain, Jonathan D.
New York, N. Y. (Cornell Univ.)

Akins, Cary W.
Red Wing, Minn. (Harvard)

Albeck, Joseph H.
Brooklyn, N. Y. (Columbia)

Anane-Sefah, John C.
Accra, Ghana (Yale)

Anderson, Frank H.
Berwyn, Pa. (Harvard)

Anderson, T. McDowell, Jr.
Arlington, Va. (Princeton)

Angoff, Gerald H.
Newton Centre, Mass. (Harvard)

Applegate, Clarence W.
Tucson, Ariz. (Oberlin)

Ault, Kenneth A.
Denver, Colo. (Massachusetts Inst. of Tech.)

Barkin, Roger M.
Great Neck, N. Y. (Brandeis)

Bear, David M.
Akron, Ohio (Harvard)

Bennett, Michael I.
Toronto, Ontario, Canada (Harvard)

Bennion, Lynn J.
Palo Alto, Calif. (Harvard)

Benson, James W., Jr.
Aptos, Calif. (Stanford)

Berv, Kenneth R.
Oceanside, N. Y. (Yale)

Blumenthal, Eileen
Oceanside, N. Y. (Radcliffe)

Boeteher, David A.
Evanston, Ill. (Princeton)

Bough, Edward W.
Chicago, Ill. (Loyola Univ.)

Bours, William A., 4th
Wilmington, Del. (Stanford)

Breed, R. Huntington, 2d
Poughkeepsie, N. Y. (Yale)

Brener, Anthony C.
Princeton, N. J. (Princeton)

Brondfield, Erie S.
Roslyn Heights, N. Y. (Harvard)

Browne, Kay F. S.
Cranbury, N. J. (Mount Holyoke)

Camfield, Peter R.
Ottawa, Ontario, Canada (Queen's Univ.)

Cannon, Woodward
Lincoln, Mass. (Harvard)

Citron, John M. T.
North Miami, Fla. (Williams)

Clarke, L. John
Buffalo, N. Y. (Harvard)

Cohen, Philip
Brooklyn, N. Y. (Columbia)

^d**Colehamiro, Stephen A.**
Brooklyn, N. Y. (Brooklyn Coll. of The City Univ. of N. Y.)

^d**Commette, James A.**
Beverly, Mass. (College of the Holy Cross)

Cooperman, Oliver B.
Fords, N. J. (Dartmouth)

^d**Coppe, Michael R.**
New Britain, Conn. (Fordham)

^d**Costello, John P.**
Poughkeepsie, N. Y. (Fairfield)

Crockett, D. Shan
Cincinnati, Ohio (Cornell Univ.)

Davidoff, Ira G.
Kew Gardens Hills, N. Y. (Massachusetts Inst. of Tech.)

Davies, John A. K.
Brookline, Mass. (Harvard)

Davis, Charles A.
Greenburg, Pa. (Massachusetts Inst. of Tech.)

Dean, Peter B.
Cincinnati, Ohio (Cornell Univ.)

Dellinger, E. Patches
Hampton, N. J. (Swarthmore)

^d**Diehl, Kenneth R.**
Harrisburg, Pa. (Cornell Univ.)

Di Giacinto, George V.
Yonkers, N. Y. (Columbia)

Dixon, Jonathan A.
Farmington, Conn. (Harvard)

Duhme, David W.
St. Louis, Miss. (Harvard)

Emans, John B., 2d
Randolph, Vt. (Harvard)

Eriesson, Charles D.
Fairfax, Va. (Harvard)

Fareed, George C.
Los Angeles, Calif. (Univ. of California, Berkeley)

Ferber, Richard A.
Chicago, Ill. (Harvard)

Fernbach, Barry R.
Valley Stream, N. Y. (Colgate)

Fisher, Richard I.
Coral Gables, Fla. (Harvard)

HMS

Folland, Edward D.
Salt Lake City, Utah (Yale)

^d**Frankel, Jerold M.**
Atlanta, Ga. (Amherst)

Fredlund, Paul N.
Minneapolis, Minn. (Harvard)

Freedberg, Leonard E.
Brookline, Mass. (Harvard)

Friedenson, Daniel J.
Brooklyn, N. Y. (Columbia)

Gerson, Donald E.
Dayton, Ohio (Harvard)

Girshon, Deanna P.
Jersey City, N. J. (Rutgers)

Gittinger, John W., Jr.
Annandale, Va. (Oberlin)

Goldman, Mitchell H.
Quincy, Mass. (Brandeis)

Goldsmith, George H., Jr.
New Orleans, La. (Washington Univ.)

Good, Michael I.
New Ulm, Minn. (Univ. of Minnesota)

Goodman, William S.
Babylon, N. Y. (Harvard)

Gottesman, Michael M.
Flushing, N. Y. (Harvard)

Green, Mark R.
South Norwalk, Conn. (Harvard)

Greenblatt, David J.
Newton, Mass. (Amherst)

Groat, Robert L.
Greensboro, N. C. (Davidson)

Gross, Peter L.
Swampscott, Mass. (Harvard)

Gunderson, Paul E.
Enumclaw, Wash. (Harvard)

The first day begins in Amphitheater C. It has both serious



1970

Gustavson, Edward E.
Northbrook, Ill. (Gustavus Adolphus)

Hafner, Daniel J.
Newell, S. D. (Boston Univ.)

Helpern, Joan M.
New York, N. Y. (Radcliffe)

Herriot, S. Jean
Palo Alto, Calif. (Radcliffe)

Herzog, James M.
Lockport, N. Y. (Harvard)

Howell, Stephen B.
Lexington, Mass. (Univ. of Chicago)

Hyman, Frederic E.
Brooklyn, N. Y. (Columbia)

Irwin, Charles F.
Tipp City, Ohio (Harvard)

Jamison, W. Glenn
New Wilmington, Pa. (Westminster College)

Kempf, Raymond A.
Utica, N. Y. (Fordham)

Kern, David E.
Cincinnati, Ohio (Princeton)

Kopf, Gary S.
Plainview, N. Y. (Columbia)

Krohn, Melvyn R.
Brooklyn, N. Y. (Brooklyn Coll. of The City Univ. of N. Y.)

Kulezyeki, Anthony, Jr.
Easton, Pa. (Princeton)

Landres, Richard T.
Encino, Calif. (Stanford)

Lanken, Paul N.
Nutley, N. J. (Harvard)

Lieber, Michael M.
Arlington, Va. (Harvard)

Liebow, Charles
Brooklyn, N. Y. (New York Univ.)

Lieff, Jonathan D.
Newark, N. J. (Yale)

Lozner, Eugene C.
Syracuse, N. Y. (Amherst)

Maekenzie, Thomas B.
Denver, Colo. (Harvard)

MaeLean, Paul D., Jr.
Potomac, Md. (Yale)

Meyers, Joel D.
Houston, Texas (Dartmouth)

Millis, Michael B.
Toledo, Ohio (Harvard)

Neaves, William B.
Spur, Texas (Harvard)

Noble, R. Michael C.
Vancouver, B. C., Canada (Univ. of British Columbia)

Oster, Charles N.
Beloit, Wis. (Univ. of Wisconsin)

Ottesen, Eric A.
Cincinnati, Ohio (Princeton)

Pashler, Josephine E.
Schenectady, N. Y. (Radcliffe)

Pearlman, Alan S.
Rochester, N. Y. (Williams)

Peppercorn, Margaret T. B.
New York, N. Y. (Radcliffe)

Pierce, R. Wendell
St. Louis, Miss. (Harvard)

Poek, Randolph W.
Coraopolis, Pa. (Allegheny)

Raaf, John H.
Portland, Oregon (Harvard)

Rabb, James M.
Cambridge, Mass. (Harvard)

Raskin, Stephen P.
Silver Spring, Md. (Brandeis)

Ribner, Bruce S.
Brooklyn, N. Y. (Princeton)

Richardson, John M.
Tyler, Texas (Harvard)

Robinson, Richard A.
Levittown, Pa. (Rutgers)

Rogers, Jeffrey L.
Bethesda, Md. (Dartmouth)

Romm, Fredric J.
Brooklyn, N. Y. (Columbia)

Rosenfeld, Alvin A.
Brooklyn, N. Y. (Cornell Univ.)

Rosenthal, Susan N.
Tenafly, N. J. (Radcliffe)

Ross, Michael E.
Portland, Conn. (Yale)

Sandberg, Glenn W., Jr.
Denver, Colorado (Columbia)

Schulman, Carol A. B.
Silver Spring, Md. (Radcliffe)

Shelton, James H.
Dallas, Texas (Harvard)

Simmons, Jeffrey L.
Marblehead, Mass. (Harvard)

Simson, Michael B.
Grosse Pointe, Mich. (Harvard)

Sklar, Marshall D.
Camden, N. J. (Brown)

Smith, Howard G.
Pittsburgh, Pa. (Princeton)

Soll, Andrew H.
Los Angeles, Calif. (Pomona)

Solomons, Noel W.
Cambridge, Mass. (Harvard)

Stein, Richard S.
Lincolnwood, Ill. (Harvard)

Stevens, Rose Marie
Rochester, Mich. (Manhattanville)

Tenney, James H.
Briarcliff Manor, N. Y. (Harvard)

Tew, Richard H.
Richland, Wash. (Univ. of Washington)

Thornton, Malcolm E.
Glastonbury, Conn. (Fairleigh Dickinson)

Veazey, James M., Jr.
Decatur, Ga. (Massachusetts Inst. of Tech.)

Warren, John W.
Wichita, Kans. (Univ. of Michigan)

Weens, Joan H.
Atlanta, Ga. (Radcliffe)

Weiler, Mary M.
Burt, N. Y. (Vassar)

Weissman, Jack B.
Brooklyn, N. Y. (New York Univ.)

Wilkoff, William G.
Pleasantville, N. Y. (Dartmouth)

Williams, Sankey V.
Nicholasville, Ky. (Princeton)

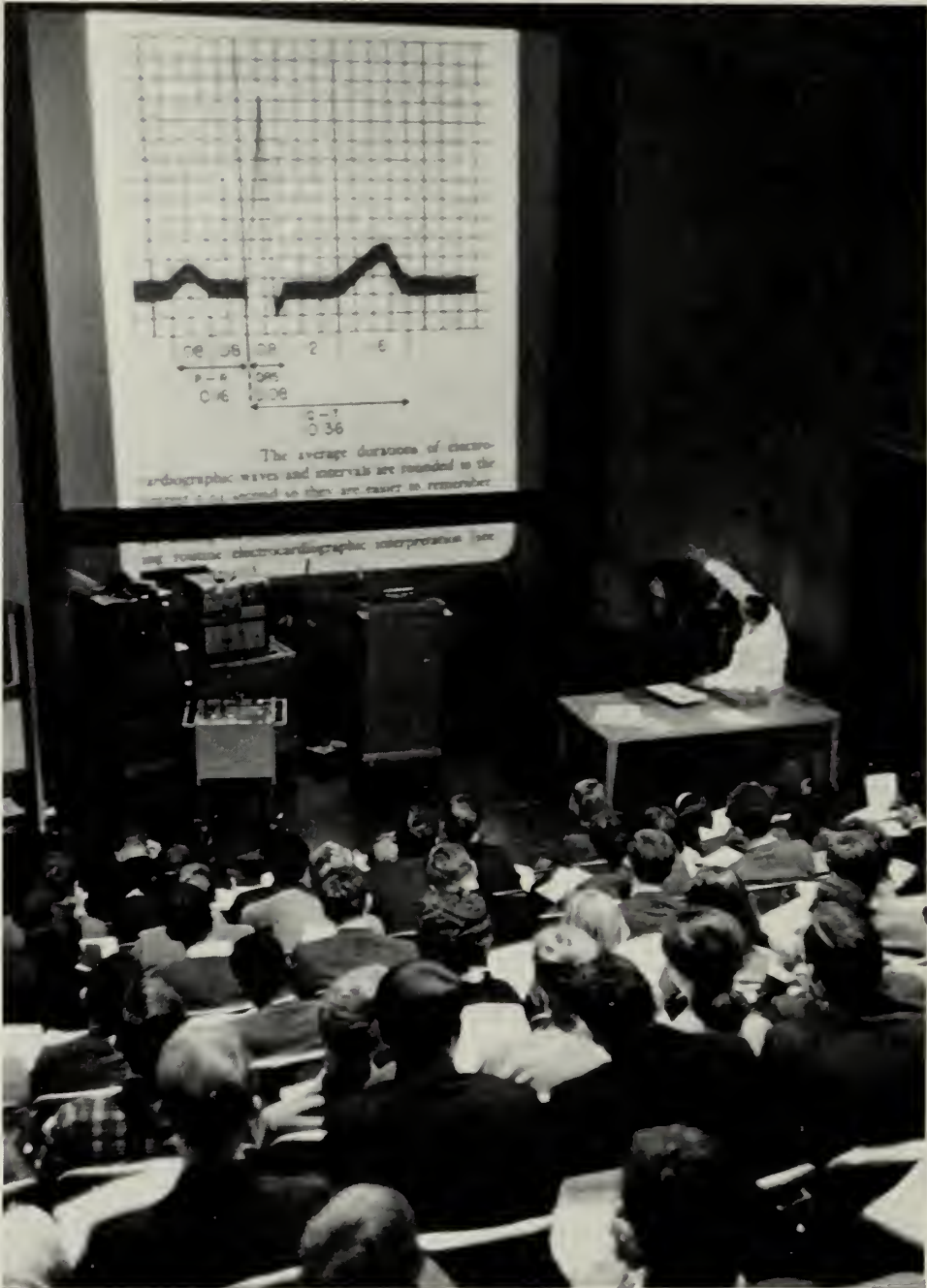
Wyler, David J.
Scarsdale, N. Y. (Brown)

Yee, Robert D.
San Francisco, Calif. (Harvard)

and humorous moments as students are welcomed by the Faculty.



"Introduction to the Clinic" is the students' first medical lecture. It was given in the Sherman Auditorium, Beth Israel Hospital, by Dr. Herrman L. Blumgart '21 and his colleagues. By using "Heart Block" as his topic, Dr. Blumgart first initiated the students into their future ethical behavior towards patients; he traced the medical history of heart block and then took everyone on an imaginary tour of many HMS Departments, showing how interdisciplinary knowledge, integrated by the physician, is essential in the care of the patient.



INSIDE HMS:

Summer Research Study Stimulates Student

by Richard P. Kluft '68

SEVERAL lines of circumstantial evidence suggest that sex hormones influence the amount of dream-time (D-time) in the sleep of human subjects. Dr. L. S. Slawkenberg, in unpublicized studies, has found evidence that in some female subjects, D-time may fluctuate throughout the menstrual cycle in apparent conjunction with estrogen and progesterone levels. In addition, data from many sources indicates that D-time, after falling from the high (45-65%) levels in the neonate to 15% in late childhood, rises again into the period of late adolescence to 25%, and declines over the years from 25 to 70, to about 13-18% in the aged. These provocative observations leave many questions unanswered. Proof is lacking that sex hormones are more than casually related to catamenial changes and-or to maturation and aging. Therefore, it was proposed by this worker to attempt the designing of experiments to determine whether or not the elevation of male sex hormone levels might result in significant quantitative changes in D-time.

The following projects were envisioned:

1. A comparison of D-time in groups of normal and castrated adult male white rats before, during, and subsequent to androgen administration.
2. The carrying out of longitudinal studies of D-time changes in male geriatric patients before, during, and after testosterone treatment.
3. Attempts to locate and study for D-time differences a pair of identical twins discordant for eunuchoidism or hypogonadism.

The fate of these projects can be summarized briefly:

1. The rat study required animals with surgically implanted electrodes. The subjects were first to undergo another study, in the course of which most perished.

2. A group of forty patients was screened for suitability to the study and willingness to participate. Those selected were volunteers not receiving any medication. They were reasonably coherent, cooperative, and considered unlikely to attempt escape. One had "chronic brain

syndrome (secondary to) alcoholism," while the remainder suffered from "chronic brain syndrome (secondary to) arteriosclerotic vascular disease." In all cases, the risk of atypical brain wave patterns was accepted as inevitable. It was decided that if their EEG tracings could be deciphered, they would be suitable, since each patient constituted a self-contained longitudinal study.

From the list of forty, ten were interviewed more extensively. Three men were selected to join a fourth, already under study by Dr. Slawkenberg. In time several difficulties emerged. One patient's mental condition deteriorated rapidly, and he became uncontrollable after a month of study. Shortly after the completion of the pre-control nights, during which the subject becomes acclimated to the laboratory so that stress does not interfere with D-time, it was discovered that two subjects gave EEG tracings which could not be interpreted. The fourth patient is still under study, but his frequent escapes limit his availability.

A fifth volunteer was recruited and proved cooperative, but, after six weeks of study, he was transferred to another institution.

3. A delay in the confirmation of the grant for this work forestalled the elaborate task of locating twins of the desired characteristics. A search of hospital patients, however, lead to the discovery of a young man in his middle twenties who had agenesis of the left testicle and had lost the right in a crush injury at age 16. He was scheduled for testosterone therapy. Permission for study was given only after the patient, considered violent, acquiesced and indicated an interest in the project. After arrangements had been made to set up a special ward room, on the first day of testing, a woman who usually runs the EEG to be used in this experiment threatened to quit her job if "her" machine were used in the study. As an anti-vivisectionist, she felt it her prerogative to oppose anything done by medical students. The doctor in charge of this division refused to see this writer or to acknowledge his complaints. He

reportedly did not want to offend the woman who ran the EEG.

Apart from the above, this worker took part in three other experiments:

1. A study of the effect of a tryptophan-free diet on sleep and dream patterns in the rat was carried out. Adult white rats with electrodes implanted in the occipital cortex, hippocampus, and neck muscles were monitored for five-hour periods by EEG before, during, and after a 30-day period on a tryptophan-free diet. The only clearcut effect of the elimination of this serotonin precursor was a lengthening of the average cycle time between the end of one D-period and the end of the next, from 8.83 minutes on the normal diet to 10.62 minutes on the tryptophan-free diet. D-time itself was unaffected. The meaning of this is uncertain. A paper on this work was presented in November, 1965, to the Association for the Psychophysiological Study of Vertebrate Behaviours. It was entitled "The Effect of Certain Restricted Diets on Sleep and Dream Patterns in the Kunsmer Strain L-17 Rat," by Slawkenberg, Zallinger, Binn, Jones, Klein, and this investigator.

2. Preliminary studies of the effect of sensory deprivation on dream time, carried out with M. Zallinger in the laboratory of Dr. Slawkenberg, indicate the possibility that D-time is significantly increased by sensory deprivation.

3. A study of the effect of four days of dream-deprivation upon the brain levels of serotonin and acetylcholine in Kunsmer strain L-17 rats was carried out in cooperation with a group in New Haven. The findings were provocative but statistically inconclusive. Further work is planned.

This worker takes this opportunity to express his sincere gratitude to Dr. L. S. Slawkenberg, who gave generously of both his time and energy in an attempt to ameliorate the ultimate course of these experiments. Dr. Slawkenberg constantly encouraged this investigator with a quotation from Dr. S. Johnson's classical paper, *Rasselas* (a dissertation on the art of flying), "Many things difficult to design prove easy to performance."



Forerunner to the BIH—a converted store.



Mansion into hospital—the first BIH.



Dedication day for the first BIH held exactly fifty years ago and below the modern BIH—a far cry from the mansion.



Beth Israel Hospital: Fifty Years for Science and Humanity

ALL YEAR BETH ISRAEL HOSPITAL has basked in its Golden Anniversary glow. But October 23 climaxed the celebrations and observance in Boston with a special "Beth Israel Hospital Week." There was the grand Golden Anniversary Ball—an "elegant salute to the past and an enthusiastic toast to the future;" and, throughout the city, exhibits—on public display—showed both historical and future aspects of the Hospital's development. During the year public lectures were given on major health problems. These and other celebrations were all motivated by a remarkably apt theme, "The Hospital: A Center for Community Health."

More than fifty years ago the very same theme influenced forces to bring into being a hospital known as the Mount Sinai Hospital. This important forerunner to the Beth Israel Hospital we know today was established in 1902—in a converted store in Roxbury, Mass. The turn of the century had brought a large wave of Jewish immigrants into the Boston area; many were too poor to afford medical aid, and too unfamiliar with the language to communicate their needs. Out-patient care was sorely required by these people and at Mount Sinai Hospital they could get it in an atmosphere in which they felt secure. By 1905, more than 6000 patients were being treated annually in eight different clinics, but soon the need for proper in-patient facilities became acute.

The Jewish community responded to the need by having the first large fund-raising drive for the Hospital. In 1910, Mrs. Morris Marks organized a committee of women to raise funds, this time, for a new hospital. The following year the Beth Israel Hospital Association was formed, and in 1916 it purchased the Dennison Estate in Roxbury and thus was established the first Beth Israel Hospital. In its fourteen years of service the Mount Sinai Hospital had always pursued three objectives which have since become Beth Israel Hospital traditions: it had treated thousands of patients; initiated research in pulmonary tuberculosis;

and organized a home obstetrical service—through which Tufts Medical School students received training.

That first Beth Israel Hospital had 45 beds and a medical staff of 23 doctors. It maintained the following principles: "... to give medical and surgical aid and care, dispensary and out-patient service to the sick and disabled of any race, creed or color, and to carry on such educational, philanthropic and scientific activities and functions as are a part of efficient and modern hospital service." The principles have not changed.

But growth in the next decade was swift. A School of Nursing was opened in 1918, with ten students in the first class. By 1921, some 43 patients were being admitted daily, but—in accord with the Hospital's custom—only half of them were charged fees. As the number of patients increased so did the scope of the services, but still hundreds of patients were being turned away annually and it was all too evident that the space and facilities were inadequate.

A new phase in the Hospital's development was about to take place, and it did, under the leadership of Albert A. Ginzberg, president of the Beth Israel Hospital Association. He initiated a "gigantic" fund raising drive to build another new Beth Israel Hospital that would "be numbered among the leading medical institutions in the nation." In 1924, the Association purchased the land in Boston on Brookline Avenue, chosen, it has been said, for its proximity to the Harvard Medical School.

The new Hospital was opened in 1928. Within a month over 275 patients had been admitted and over 125 operations performed. There was a permanent house staff of 15—six doctors in medicine, six in surgery and three interns. Among the "modern and complete" equipment was an oxygen chamber—in all the country there were only two others like it. Almost immediately, teaching affiliations were established with HMS and with Tufts Medical School. A Medical Research Department was established under Dr. Herrman L. Blumgart '21, and in 1931 a Department of Surgical Research with Dr. Jacob Fine '24, as chief.

With the depression came an urgent need for free medical facilities, and in 1935, 79% of the total costs of ward services were expended for giving free care. That same year the Hospital became a constituent agency of the Combined Jewish Philanthropies.

Throughout the next decade expanding community needs and medical and scientific advances made it necessary for more patient care and research facilities. Another fund-raising campaign was begun in 1946, and, once again, the Jewish community responded quickly and generously. As a result of this, by 1949 the Yamins Research Building was dedicated and one year later the South Building.

But the growth of Beth Israel Hospital has never been one of physical expansion alone; as the number of buildings increased, so too did the quality of patient care, diversification of research programs and the calibre of education.

In the early forties, research, largely limited to coronary disease, made major advances in the reduction of heart strain; first with the thyroidectomy and later through the development of suitable drugs for drug therapy.

In the 1950's research, supported by the government, industry and other sources, had grown to include cancer study, blood investigations and expanded cardio-vascular programs. All this led to the development and introduction of the electronic cardiac pacemaker and blood volume machine.

In 1960, the largest building program to date was launched; and just last year the Rabb Building was dedicated and many renovations were made throughout the Hospital.

This year alone, within the 372-bed hospital, a medical staff of 690 treated over 12,000 in-patients, 6,500 operations were performed and 18,500 emergency cases were received.

The evolution of the Beth Israel Hospital is also the story of today's emerging modern medicine. Each breakthrough in theory or application, each new medical or surgical technique, each advance in education or research has been applied—and often initiated—to make the Hospital what it is today.

